



**New England Consulting
Grp of Gfld, Inc.**
Tom J. Perrone, CLU
President
2514 Boston Post Rd
C-2
Guilford, CT 06437
203-453-0471
tpnecgginc@comcast.net
www.necgg.com



IRA Beneficiaries and Medicaid Planning

Table of Contents

Healthcare in Retirement	4
What health care benefits are available in retirement?	4
Medicare	4
Medigap	5
Medicaid	5
Military benefits	6
Choosing a continuing care retirement community	7
Choosing a nursing home	7
Beneficiary Designations for Traditional IRAs and Retirement Plans	8
What is it?	8
The law may limit your choices	8
Your choice of beneficiary usually will not affect required minimum distributions during your lifetime	9
Your choice of beneficiary will affect required distributions after your death	9
Other considerations when choosing beneficiaries	10
Designated beneficiaries vs. named beneficiaries	10
Primary and secondary beneficiaries	10
Having multiple beneficiaries	11
When do you have to choose your beneficiaries?	11
Paying death taxes on IRA and plan benefits	12
Your options when choosing your beneficiaries	12
Long-Term Care Insurance (LTCI)	13
What is long-term care insurance (LTCI)?	13
How is it useful as a protection planning tool?	13
How much does it cost?	14
Who should purchase LTCI?	14
How much coverage is enough?	14
How do you compare policies and providers?	14
What are the tax ramifications?	15



Evaluating Long-Term Care Insurance (LTCI) Policies Discussion	16
What is evaluating, comparing, replacing, and conserving long-term care insurance (LTCI)?	16
How should you evaluate and compare long-term care insurance (LTCI) policies?	16
How should you compare companies?	17
What about replacing or updating your policy?	18
What about conserving your policy (LTCI)?	18
Medicaid Planning Goals and Strategies	19
Why is Medicaid planning important?	19
What are the goals of Medicaid planning?	19
What are the primary tools and strategies for attaining these goals?	19
Durable power of attorney	21
How does long-term care insurance factor in?	21
What are the drawbacks to Medicaid planning?	22
Look-back period	22
Penalties	22
Adverse tax consequences	22



Healthcare in Retirement

What health care benefits are available in retirement?

Health care in retirement is available from many sources. Government programs (such as Medicaid and Medicare) offer numerous health care benefits. However, you may need to purchase supplemental health insurance or Medigap, as well. Most Americans are eligible to begin receiving Medicare benefits at age 65, but qualifying for Medicaid may require some planning on your part. In addition to these resources, you may also be entitled to military health care benefits if you are a veteran, retired servicemember, or the spouse or widow of a veteran or retired servicemember. Continuing care retirement communities and nursing homes also offer health care services for older individuals. Depending on your specific needs and circumstances, you may use any number of these resources during your retirement years.

Medicare

In general

Medicare is a federal health insurance program created in 1965. Medicare primarily assists those who are 65 or older, but if you are disabled or have kidney disease, you may be eligible for Medicare coverage no matter what your age. Medicare currently consists of Part A (hospital insurance), Part B (medical insurance), Part C (which allows private insurance companies to offer Medicare benefits), and Part D (which covers the costs of prescription drugs), with each part having its own eligibility requirements. You may qualify for one or more parts, or you may choose to accept or decline coverage if you are eligible. Many health policies limit coverage for Medicare-eligible individuals regardless of whether they have accepted Medicare coverage.

Medicare benefits for disabled individuals

Under certain conditions, the disabled are eligible to enroll in Medicare before age 65. If you have been receiving (or have been entitled to receive) Social Security disability benefits for at least 24 months (not necessarily consecutively), you may be eligible to enroll in Medicare. To enroll, you must be entitled to benefits in one of the following categories:

- A disabled individual of any age receiving worker's disability benefits
- A disabled widow or widower age 50 or older
- A disabled beneficiary who is older than age 18 and receives benefits based on a disability that occurred before age 22

In addition, Medicare may be available at any age if you are disabled as a result of chronic kidney failure requiring dialysis or a kidney transplant.

Qualified Medicare Beneficiary program

If you have limited means, you may be eligible for the Qualified Medicare Beneficiary (QMB) program. Here, your state's Medicaid program may pay for your Medicare Part B premium, Part A and Part B deductibles, and coinsurance requirements. Eligibility rules may vary from state to state, but in general, you must meet the following three criteria:

- You must be entitled to Medicare Part A
- Your income must be at or below the national poverty level
- The value of your assets must be below a certain level

There are also other related programs that have somewhat less restrictive eligibility requirements.



Medigap

In general

Medigap is supplemental insurance specifically designed to cover some of the gaps in Medicare coverage. Although the name might lead you to believe otherwise, Medigap is provided by private health insurance companies, not the government. However, Medigap is strictly regulated by the federal government.

There are 10 standard Medigap policies available (Plans E, H, I, and J are no longer available for sale, however, if you already have one of these plans you can keep that plan). All plans may not be offered in your state, yet all are standardized and certified by the U.S. Department of Health and Human Services so that each plan provides exactly the same kind of coverage no matter what state you live in (except for Massachusetts, Minnesota, and Wisconsin, which have their own standardized plans). Every Medigap policy offers certain basic core benefits, such as coverage of certain Medicare Part A and B coinsurance and co-payments. Other plans offer additional benefits, such as coverage of Medicare Part A and B deductibles, and charges that result when a provider bills more than the Medicare-approved amount for a service.

Medicaid

In general

Medicaid provides medical assistance to aged, disabled, or blind individuals, or to needy, dependent children who could not otherwise afford the necessary medical care. Medicaid pays for a number of medical costs, including hospital bills, physician services, home health care, and long-term nursing home care. Each state administers its own Medicaid programs based on broad federal guidelines and regulations. Within these guidelines, each state performs the following: (1) determines its own eligibility requirements; (2) prescribes the amount, duration, and types of services; (3) chooses the rate of reimbursement for services; and (4) oversees its own program.

Applying for benefits

To apply for Medicaid, you must use a written application on a form prescribed by your state and signed under penalties of perjury. Give the application to your state Medicaid office. Typically, you will need to provide proof of age, marital status, residence, and citizenship, along with your Social Security number, verification of receipt of government benefits, and verification of your income and assets. A responsible individual can complete the application on behalf of an incompetent or incapacitated individual.

Eligibility

To qualify for Medicaid, you must meet two basic eligibility requirements. First, you must be considered categorically needy because of blindness, disability, old age, or by virtue of being the parent of a minor child. Next, you must be financially needy, which is determined by income and asset limitation tests. States have much discretion in determining which groups their Medicaid programs will cover, but as participants in Medicaid, they must provide coverage for all residents who are considered categorically needy.

Caution: State and federal rules regarding Medicaid eligibility change frequently.

Transfer of assets

Because Medicaid eligibility is based on your income and other resources, state Medicaid authorities are interested in knowing whether you have tried to transfer assets out of your name in order to qualify for Medicaid. When you apply for Medicaid, the state has the right to examine your finances and those of your spouse as far back as 60 months from the date you are eligible for medical assistance under the State plan. Only certain transfers are prohibited. Fair market transactions will typically be considered legitimate, but if you transfer assets for less than fair market value around the time you apply for Medicaid, the state will presume that the transfer was made solely to help you qualify for Medicaid.



Planning goals and strategies

As mentioned earlier, the state has the right to look into your financial transactions to determine whether you have transferred assets solely to qualify for Medicaid. However, the state may count only the income and assets that are legally available to you for paying your bills. Consequently, several methods have been developed to help you shelter your assets from the state and facilitate Medicaid qualification. Proper planning can help you to qualify for Medicaid, shelter "countable" assets, preserve assets (including the family home) for loved ones, and protect the healthy spouse (if any).

Medicaid qualifying trusts

To qualify for Medicaid, both your income and the value of your other assets must fall below certain limits (which vary from state to state). A trust helps you to qualify for Medicaid because it can shelter your income and assets, making them unavailable to you. The state Medicaid authorities cannot consider assets that are truly inaccessible to the Medicaid applicant. Therefore, anything that stays in an irrevocable trust will lie outside of your financial picture for Medicaid eligibility purposes. If you are looking for a strategy to shelter your resources, one of the following may be appropriate: (1) an irrevocable income-only trust, (2) an irrevocable trust in which the creator of the trust is not a beneficiary, (3) a Miller trust, or (4) a special needs trust.

Protection of principal residence

In certain cases, the state may be entitled to seek reimbursement for Medicaid payments by forcing the sale of your principal residence if you are a Medicaid recipient. Medicaid planning tools have been devised to protect your home, but their effectiveness varies. Therefore, it is important to weigh the costs and benefits of each device carefully. If you are looking for a strategy to preserve your home for loved ones, one of the following four methods may be appropriate: (1) an outright transfer or gift of the home, (2) a transfer subject to life estate, (3) a transfer subject to special power of appointment, or (4) a transfer in trust.

Medicaid and long-term care insurance

Long-term care (LTC) insurance can be useful as part of your Medicaid planning strategy. Your LTC policy can subsidize your nursing home bills during the Medicaid ineligibility period caused by your transfer of assets to third parties. Thus, it may be possible for you to give your assets away to loved ones, have the security of paid nursing home bills during the ineligibility period, and qualify for Medicaid when the LTC policy runs out.

Medicaid liens and estate recoveries

Federal law requires states to seek reimbursement from Medicaid recipients for Medicaid payments made on their behalf. Cost-recovery actions against the assets of Medicaid recipients may come in two forms: (1) real or personal property liens and (2) recovery from decedents' estates. A Medicaid lien makes it impossible for you to sell or refinance your house without the state's knowledge and ability to collect what it is owed. As for recovery from decedents' estates, states also can seek reimbursement from your probate estate after you die. States have the option to expand the definition of estate to include all nonprobate assets as well.

Divorce and Medicaid

From a purely financial perspective, divorce can be a practical move and may actually be used as a Medicaid planning tool. When a spouse enters a nursing home and applies for Medicaid, the couple's assets must be pooled together and totaled to determine what portion the healthy spouse may keep. After this Spousal Resource Allowance has been determined, the Medicaid applicant must transfer assets representing the amount of the allowance to the healthy spouse. The remaining assets must be spent on the institutionalized partner's medical care. A divorce court order can supersede the normal Spousal Resource Allowance rules prescribed under state Medicaid regulations. You should consult your legal advisor for further information.

Military benefits

Disability benefits, health-care benefits, and long-term care benefits are available through various military programs sponsored by the Department of Defense and the Department of Veterans Affairs (VA), formerly known as the Veterans Administration. Health care for veterans is typically available at VA hospitals and health-care facilities. In



general, active service members, retirees, and veterans other than those who were dishonorably discharged are eligible for military benefits. Survivors of servicemembers and veterans are also generally eligible for some of the same benefits. However, the rules surrounding these benefits can be complex and may change frequently. It is best to check with your military personnel office or local VA office if you have questions about any of these benefits.

Choosing a continuing care retirement community

Continuing care retirement communities (CCRCs) are retirement facilities that offer housing, meals, activities, and health care to their residents. These communities appeal to people who are currently in good health but who worry that they may need nursing care later on. The CCRC and the resident sign a contract guaranteeing that the CCRC will provide housing and nursing home care throughout the resident's life and that, in return, the resident pays an entrance fee and a monthly fee. In choosing a CCRC, you should consider factors such as the entrance fee and monthly fees, insurance requirements, the financial stability of the CCRC, its facilities and activities, and the quality of medical care provided to residents.

Choosing a nursing home

A nursing home is a licensed facility that provides skilled nursing care, intermediate care, and custodial care. Although you may prefer in-home care, you may have to enter a nursing home if you need round-the-clock care, especially if you can't get help from family or an in-home caregiver. When choosing a nursing home, you should consider factors such as the cost of the home, the quality of medical care provided, the appearance and the safety of the facilities, the ratio of staff to residents, and recreational opportunities.

Paying for nursing home care

Nursing home care can be extremely expensive, and paying for this care is a problem that weighs heavily on the minds of older Americans and their families. There are several resources you can use in planning for this expense, including self-insurance, long-term care insurance, Medicare (limited benefits), Medicaid, and military benefits.



Beneficiary Designations for Traditional IRAs and Retirement Plans

What is it?

If you have a traditional IRA or participate in an employer-sponsored retirement plan such as a 401(k) plan, you are generally required to complete a beneficiary designation form with the IRA custodian or plan administrator. As you may know, the beneficiary or beneficiaries you name (you can generally name more than one) will receive the remaining funds in your IRA or plan account after you die. What you may not realize is that your choice of beneficiary may have implications in other important areas, including:

- The size of the annual required minimum distributions (RMDs) that you must take from the IRA or plan during your lifetime
- The rate at which the funds must be distributed from the IRA or plan after your death
- The combined federal estate tax liability of you and your spouse (assuming you are married and expect estate tax to be an issue for one or both of you)

Because of these and other issues, choosing beneficiaries for your IRA or plan is often a significant financial decision. This is particularly true if your financial situation is complicated, and if your retirement accounts make up a substantial portion of your total assets. It is in your best interest to select proper beneficiaries with the help of a tax advisor and/or other qualified professionals. Your financial and personal circumstances will likely evolve over time, and you are often free to add or remove beneficiaries whenever you want (though certain restrictions may apply, as discussed below). You should periodically review your beneficiary choices to make sure they are still the right choices.

Tip: Employer-sponsored retirement plans include qualified stock bonus, pension, or profit-sharing plans. A 401(k) plan is a type of employer-sponsored retirement plan. If you are unsure if you participate in an employer-sponsored retirement plan, ask your employer. This discussion also applies to you if you are a schoolteacher or an employee of a tax-exempt organization or state or municipal government and participate in an eligible Section 457 plan or a Section 403(b) plan.

Caution: This discussion does not apply to Roth IRAs. Roth IRAs have their own special beneficiary designation considerations.

The law may limit your choices

You are often free to name any beneficiaries you choose for your IRA or plan, but there are exceptions. If you are married and want to name a primary beneficiary other than your spouse, there may be restrictions on your ability to do so. No matter which state you live in, federal law may require that your surviving spouse be the primary beneficiary of your interest in some employer-sponsored retirement plans (such as 401(k) plans), unless your spouse signs a timely, effective written waiver allowing you to name a different primary beneficiary. You should consult your plan administrator for further details.

IRAs are not subject to this federal law, although your state may impose its own requirements. For example, if you live in one of the community property states, your spouse may have legal rights in your IRA regardless of whether he or she is named as the primary beneficiary. In addition, if your roles are reversed (your spouse is the IRA owner or plan participant, and you the primary beneficiary) and you die first, state law may prevent your surviving spouse from changing the beneficiary designation after your death (unless you grant your spouse the power to make these changes in a will or other document). You should consult an estate planning attorney for details regarding these and other state issues.



Your choice of beneficiary usually will not affect required minimum distributions during your lifetime

Under federal law, you must begin taking annual RMDs from your traditional IRA and most employer-sponsored retirement plans (including 401(k)s, 403(b)s, 457(b)s, SEPs, and SIMPLE plans) by April 1 of the calendar year following the calendar year in which you reach age 70½ (your "required beginning date"). With employer-sponsored retirement plans, you can delay your first distribution from your current employer's plan until April 1 of the calendar year following the calendar year in which you retire if (1) you retire after age 70½, (2) you are still participating in the employer's plan, and (3) you own five percent or less of the employer.

Your choice of beneficiary will not have an impact on the calculation of RMDs during your lifetime in most cases. An exception exists if your spouse is your sole designated beneficiary for the entire distribution year, and he or she is more than 10 years younger than you. Also, your choice of beneficiary can impact the tax deferral and other consequences for your beneficiaries.

Caution: The calculation of RMDs is complex, as are the related tax and estate planning issues. Consult a tax professional.

Your choice of beneficiary will affect required distributions after your death

After your death, your IRA or plan beneficiary (or beneficiaries) will generally have to receive the inherited retirement funds at some point. Distributions from an inherited IRA or retirement plan are referred to as required post-death distributions. With some exceptions, these distributions must begin by the end of the year following the year of your death.

Caution: Your beneficiary generally must withdraw the distribution required for the year of your death if you haven't yet taken it.

For federal income tax purposes, post-death distributions are treated the same as distributions you take during your lifetime. (State income tax may also apply.) The portion of a distribution that represents pretax or tax deductible contributions and investment earnings will be subject to tax, while the portion that represents after-tax contributions will not be. Your beneficiary's income tax bracket will determine how heavily the funds are taxed after your death. This may be something to consider when choosing your beneficiaries.

In addition, different types of beneficiaries will have different post-death options and be subject to different payout periods. The payout period is important because the longer the funds can remain in the IRA or plan, the more time they have to benefit from tax-deferred growth. Also, a longer payout period spreads out the income tax liability on the funds over more years. In most cases, an individual designated as a beneficiary can take post-death distributions over his or her remaining life expectancy. The younger the individual, the longer the payout period. A surviving spouse can generally use this method, but often has other options as well (such as the ability to roll over the inherited funds to the spouse's own IRA or plan). Special post-death rules apply if you name a trust, a charity, or your estate as beneficiary.

Caution: Nonspouse beneficiaries cannot roll over inherited funds to their own IRA or plan. However, a nonspouse beneficiary can make a direct rollover of certain death benefits from an employer-sponsored retirement plan to an inherited IRA (traditional or Roth).

Be aware that your beneficiaries will be subject to a federal penalty tax if required post-death distributions are not taken, or not taken in a timely manner. The penalty tax is equal to 50 percent of the undistributed required amount for a given year. This is the same penalty tax that applies when lifetime RMDs (see above) are not taken by the applicable deadline.

Finally, the important point is that who or what you name as your beneficiary is crucial because it will ultimately determine how the funds are paid out after you die, and what portion is lost to taxes. Estate taxes may also be a factor to consider if you expect the value of your estate and/or your spouse's estate to exceed the federal applicable exclusion amount (\$5 million for 2011).

Caution: In the case of a retirement plan account, the plan may be able to specify the post-death



distribution options available to your beneficiaries. Those options may or may not be identical to the allowable options set forth in the IRS distribution rules. You should consult your plan administrator for details, as this could have an impact on your choice of beneficiaries.

Other considerations when choosing beneficiaries

Income and estate taxes are very important considerations when choosing IRA and plan beneficiaries, but they are not the only factors that should enter into your decision. Never forget that, ultimately, you are deciding who will receive your IRA or retirement plan benefits after you die. Think carefully about who you want to provide for, and about how this decision fits into your overall estate plan. Consider the value of your IRA or retirement plan in relation to the value of all of your other assets. Designating the beneficiary of a \$20,000 IRA that makes up five percent of your total assets is very different from designating the beneficiary of an \$800,000 retirement plan that makes up 80 percent of your total assets. In the first situation, your decision impacts only a small portion of your total estate. In the second situation, your retirement plan is the bulk of your estate.

Designated beneficiaries vs. named beneficiaries

Designated beneficiaries get preferential income tax treatment after your death. Being a "designated" beneficiary is not necessarily the same as being named as a beneficiary on a beneficiary designation form. IRAs and retirement plan accounts may have beneficiaries, but no designated beneficiaries. Designated beneficiaries are individuals (human beings) who are named as beneficiaries, do not share the IRA or plan account with nonindividuals, and are named in a timely manner. Charities and/or your estate can be named as beneficiaries, but they are not designated beneficiaries. A trust named as a beneficiary is not a designated beneficiary either, although the underlying beneficiaries of the trust can be designated beneficiaries under certain conditions.

The distinction between a designated beneficiary and a named beneficiary is important because designated beneficiaries generally have more flexible post-death distribution options, often resulting in more favorable income tax treatment. For example, only a designated beneficiary can use the life expectancy payout method for post-death distributions.

What happens if you have named both an individual and a non-individual (for example, a charity) as beneficiaries of your IRA or plan? Is the individual beneficiary allowed to use the life expectancy method to distribute his or her share? The answer is maybe. It depends on whether certain rules are followed. If you have left your IRA or plan to the beneficiaries in fractional amounts (as opposed to dollar amounts), the account may be divided into separate accounts up until December 31 of the calendar year following the year of your death. Then, the individual beneficiary can use his or her own life expectancy for his or her separate account. Or, the benefits due to the non-individual beneficiary can simply be paid out before September 30 of the calendar year following the year of your death. If the non-individual beneficiary has been fully paid off by the date indicated above, it is no longer considered a beneficiary for distribution purposes. (This approach can be used whether the non-individual beneficiary's share is expressed as a fractional amount or a dollar amount, but the separate accounts rules generally won't apply to pecuniary (specific dollar amount) bequests.)

Caution: If separate accounts are not established by December 31 of the year following the year of your death, or benefits are not paid to the non-individual before September 30 of the year following the year of your death, then your entire account will generally be treated as if there were no designated beneficiary.

Caution: The rules regarding separate accounts are complex. Consult a tax professional.

Primary and secondary beneficiaries

When it comes to beneficiary designation forms, your goal should be to avoid gaps. If you do not have a named beneficiary who survives you, your estate may end up as the "default" beneficiary of your IRA or plan. That typically produces the worst possible result in terms of estate and income taxes and other issues.

Your primary beneficiary is your first choice to receive your retirement assets after you die. You can name more than one person or entity as your primary beneficiary (see below--Having multiple beneficiaries). If your primary beneficiary does not survive you or decides to decline the inherited funds (the tax term for this is a "disclaimer"),



then your secondary beneficiaries (also called "contingent" beneficiaries) receive the assets. Typically, the beneficiary designation form that you complete will have separate sections for the different levels of beneficiaries.

Having multiple beneficiaries

You may generally name more than one primary beneficiary to share in the IRA or retirement plan proceeds. You just need to specify (on the beneficiary designation form) the portion of the funds that you want each beneficiary to receive. This can be expressed as fractional amounts (i.e., percentages) or as fixed dollar amounts. Fractional or percentage amounts usually make more sense, since the dollar value of the account usually fluctuates with the underlying investments and the separate account rules (discussed below) generally won't apply to pecuniary (specific dollar amount) bequests. The account does not have to be divided equally among multiple beneficiaries. For example, you can leave 60 percent to one of your primary beneficiaries, and 20 percent each to your other two primary beneficiaries.

In addition, you can designate multiple beneficiaries by name or by a grouping. For example, you might want to name your spouse as your primary beneficiary and your children as the secondary beneficiaries. You can do this by providing the full name of each person, or by listing them simply as "my spouse who survives me" and "my children who survive me."

In some cases, you may want to designate a different beneficiary for each of your retirement accounts (assuming you have more than one), or divide an account into separate subaccounts (with a separate beneficiary for each subaccount). This could potentially allow each beneficiary to use his or her own life expectancy to calculate required post-death distributions, providing greater income tax deferral for your beneficiaries in many cases. If you do this, however, you should try to plan withdrawals from the different accounts accordingly. Taking most of your distributions from one IRA or plan account could leave the beneficiary of that account with less money than you had intended.

If you have more than one beneficiary you want to provide for, the advantage of having one retirement account (or as few as possible) with multiple primary beneficiaries is reduced paperwork and record keeping. Account consolidation may also save you money in annual fees and other expenses. The drawback is that this may limit post-death options. For example, say your children are all named as primary beneficiaries of your one IRA, and they want to use the life expectancy method for post-death distributions. The calculation would generally have to be based on the age of the oldest child, subjecting the other children to a shorter payout period than they could otherwise have.

This outcome can be avoided, however, if separate accounts are established for the children at some point. An IRA or plan account with multiple designated beneficiaries can generally be split into separate accounts at any time up until December 31 of the year following the year of your death (but note that designated beneficiaries are determined by September 30). Each account and its beneficiary might then be treated separately for purposes of determining required post-death distributions.

Caution: The rules regarding "separate accounts" are complicated. Consult a tax professional.

When do you have to choose your beneficiaries?

In the past, you typically had to choose a beneficiary for your IRA or retirement plan by your required beginning date for lifetime RMDs. Your choice was then "locked in" (at least for certain purposes) on the earlier of that date or the date of your death. The final IRS regulations issued in 2002 extend the deadline for finalizing your beneficiary choices for purposes of post-death distributions until September 30 of the year following your death. This gives you greater flexibility because you are now free to change beneficiaries any time during your life. Changes made after your required beginning date usually will not affect the distributions you are taking (since your choice of beneficiary, unless it is a more than 10 years younger spouse, now has no bearing on the calculation of your RMDs during your lifetime).

The final regulation distribution rules also create significant opportunities for post-death planning. Since your IRA or plan beneficiaries are not finalized until September 30 of the year following your death, a beneficiary could either disclaim (refuse to accept) or cash out (withdraw) his or her share of the inherited funds by this deadline. That beneficiary would then be removed from the list of designated beneficiaries. Only those beneficiaries remaining as of the September 30 deadline would be considered when determining required post-death distributions from the



account.

Caution: Although the date for finalizing beneficiaries for distribution purposes is September 30 of the year following your death, an IRA or plan account can be split into separate accounts up until December 31 of that same year. Again, consult a tax professional regarding the rules for separate accounts.

Paying death taxes on IRA and plan benefits

Consult your estate planner as to the source to pay any death taxes due on your IRA and retirement plan benefits. Depending on the death tax payment clause in your will and/or trust and state law, it could be that other assets are used to pay death taxes, or it might be that the benefits will be diminished by the payment of death taxes. An important part of completing your beneficiary designations is making sure that the source of payment of death taxes does not conflict with your overall estate plan.

Your options when choosing your beneficiaries

The terms of your IRA or retirement plan may govern your beneficiary designations. As discussed, many qualified retirement plans require you to designate your spouse as beneficiary or, alternatively, that you have your spouse sign a consent and waiver. Some states (particularly community property states) may require similar spousal consent for IRAs.

Assuming you have a choice, you should carefully consider your options and seek qualified professional advice. The designation of a beneficiary can involve income taxes, estate tax, and other important non-tax issues. Often it will make sense to name your spouse as beneficiary of your IRA or retirement plan benefits. In other cases, it may make sense to name a child, grandchild, or other individual, a trust, a charity, or in rare cases, your estate, as beneficiary. Make sure you understand the advantages and disadvantages of each particular beneficiary choice.



Long-Term Care Insurance (LTCI)

What is long-term care insurance (LTCI)?

Long-term care insurance (LTCI) is a contractual arrangement that pays a selected dollar amount per day for a selected period of time for skilled, intermediate, or custodial care in nursing homes and other settings (such as home health care). Because Medicare and other forms of health insurance do not pay for custodial care, many nursing home residents have only three alternatives for paying their nursing home bills: their own assets (cash, investments), Medicaid, and LTCI. For information about Medicare and other government programs that cover only a limited amount of long-term care expenses, see *Coordination with Government Benefits*.

In general, long-term care refers to a broad range of medical and personal services designed to provide ongoing care for people with chronic disabilities who have lost the ability to function independently. The need for this care arises when physical or mental impairments prevent one from performing certain basic activities, such as feeding, bathing, dressing, transferring, and toileting--activities known as ADLs ("activities of daily living"). For more information about these activities, see *Long-term Care Insurance (LTCI) Provisions*. For details about places where you might receive long-term care, see *Types of Long-term Care*. For information about different kinds of LTCI policies and places where you might purchase them, see *Types of Long-term Care Policies*.

Long-term care may be divided into three levels:

- Skilled care--continuous "around-the-clock" care designed to treat a medical condition. This care is ordered by a physician and performed by skilled medical personnel, such as registered nurses or professional therapists. A treatment plan is created, and it is usually contemplated that the patient will recover at some point.
- Intermediate care--intermittent nursing and rehabilitative care provided by registered nurses, licensed practical nurses, and nurse's aides under the supervision of a physician.
- Custodial care--care designed to help one perform the activities of daily living (such as bathing, eating, and dressing). It can be provided by someone without professional medical skills, but is supervised by a physician.

How is it useful as a protection planning tool?

The risk of contracting a chronic debilitating illness (and the resulting catastrophic medical bills incurred) is considered by many to be one type of risk best passed on to an insurance company through the purchase of a LTCI policy.

A number of factors can increase your risk of requiring long-term care in the future. Naturally, your health status affects your likelihood of incurring a long stay in a nursing home. Indeed, people with chronic or degenerative medical conditions (such as rheumatoid arthritis, Alzheimer's disease, or Parkinson's disease) are more likely than the average person to require long-term nursing home care. And because women usually outlive the men in their lives, women stand a greater chance of requiring long-term nursing home care. However, if you already have a primary caregiver (like a spouse or child), your likelihood of needing a long stay in a nursing home will be less, particularly if you're a man. Because the cost of long-term care can be astronomical and may exhaust your life savings, purchasing LTCI should be considered as part of your overall asset protection strategy.

Example(s): Sue is a 75-year-old widow with two children, John and Jill. Sue owns her condominium apartment and has \$200,000 in liquid assets. After enjoying independence much of her life, Sue suffered a stroke and now needs help with such things as bathing, dressing, and eating. John and Jill look into home health care and discover that it will cost \$1,500 per week (or \$78,000 per year). The money that Sue had hoped to pass on to her children will instead be spent on expenses that may otherwise have been covered by an LTCI policy.



How much does it cost?

Although purchasing LTCI seems to be the easy answer to the problem of escalating long-term care costs, the premiums for LTCI can be, depending on benefit levels selected, quite expensive.

Your yearly premium for an LTCI policy depends on a number of considerations, including your age when you purchase the policy, your health, the length of the coverage period (for instance, three years, five years, or lifetime benefits), the amount of the daily benefit provided, and whether you purchase inflation protection. When buying an LTCI policy, you must also consider not only whether you can afford to pay the premiums now but also whether you'll be able to continue paying premiums in the future, when your income may be substantially decreased. For more information about the cost of LTCI and examples regarding how Medicare and Medigap may help defray some of the costs, see [Coordination with Government Benefits](#).

Who should purchase LTCI?

During the "golden years," when income typically declines, the purchase of LTCI should be carefully considered. People with significant discretionary income and substantial resources to protect for spouses, children, and other loved ones should seriously consider purchasing LTCI. Individuals with modest resources (e.g., less than \$50,000 net worth) may find the premiums unaffordable, and may qualify for Medicaid by spending down their assets and/or engaging in a little Medicaid planning.

How much coverage is enough?

Insurance protects against an event that might happen in the future. Therefore, buying enough protection is important, but affordability must also be considered. In terms of cost, you need to consider the amount of the daily benefit you want to purchase and also the length of the benefit period.

- **Daily benefit**--Most policies will let you choose your amount of coverage, typically running anywhere from \$40 to \$150 or more per day. Of course, the greater the daily benefit and the longer the benefit period, the more the policy will cost. Also, note that the cost of nursing home care varies greatly from one metropolitan area to another, so you need to know where you'll be living out the remainder of your years. Certainly, it wouldn't make sense to purchase a policy with a daily benefit of \$40 if the average daily cost of nursing homes in your area is \$250 per day--unless, of course, you have substantial resources and plan to use some of your own income to pay for care. Consumers should generally buy enough coverage to cover 50 to 100 percent of nursing home costs. If you don't plan on using your own income to supplement, you should buy enough insurance to cover 100 percent of the nursing home costs.
- **Length of benefit period**--When purchasing LTCI, you'll be asked to select a benefit period. Benefit periods generally range from one to six years, with some policies offering a lifetime benefit. You'll want to choose the longest benefit period you can afford. If you can't afford a lifetime benefit, consider choosing a benefit period that coordinates with the look-back period for Medicaid (five years). For more information about ineligibility periods, see [Look-Back Period for Medicaid](#).

Tip: The Deficit Reduction Act of 2005 gave all states the option of enacting long-term care partnership programs that combine private LTCI with Medicaid coverage. Partnership programs enable individuals to pay for long-term care and preserve some of their wealth. Although state programs vary, individuals who purchase partnership-approved LTCI policies, then exhaust policy benefits on long-term care services, will generally qualify for Medicaid without having to first spend down all or part of their assets (assuming they meet income and other eligibility requirements). Although partnership programs are currently available in just a few states, it's likely that many more states will offer them in the future.

How do you compare policies and providers?

Unfortunately, LTCI policies are not standardized. Provisions contained in policies vary greatly, and premiums charged vary as well. Therefore, you should compare policies to obtain the best amount and combination of benefits for your premium dollars.



-
- To compare policies, you should obtain sample policies and "Outlines of Coverage" from each carrier you are considering. The Outline of Coverage summarizes the policy's benefits and highlights the policy's important features. You need to read the policies carefully, ensuring that you understand each provision. There are a number of factors you should be concerned about, such as inflation protection, a full range of care (including home health care), exclusions for pre-existing conditions, and the amount of the daily benefit provided. For a description of the types of provisions typically contained in an LTCI contract, see Long-term Care Insurance (LTCI) Provisions.
 - To compare providers, you should check out the financial strength of the companies by reviewing their A. M. Best Company's ratings along with the opinions of other rating services. You can also review the company's financial statements. For more information, see Comparing and Replacing Long-term Care Insurance (LTCI) Policies.

What are the tax ramifications?

If you purchase a "qualified" LTCI policy, part (or all) of the premiums you pay pursuant to the contract may be deductible on your federal income tax return. LTCI policies issued after January 1, 1997, must meet certain federal standards to be considered qualified. However, LTCI policies issued prior to January 1, 1997, that met the long-term care insurance requirements of the state in which the contract was issued are automatically considered qualified. For more information, see Taxation and Long-term Care Insurance (LTCI).



Evaluating Long-Term Care Insurance (LTCI) Policies

Discussion

What is evaluating, comparing, replacing, and conserving long-term care insurance (LTCI)?

In some ways, comparing long-term care insurance (LTCI) policies from different insurance companies is like comparing apples with oranges. LTCI can be expensive, especially if you decide to purchase a policy particularly late in life. In addition, because LTCI policies are not standardized at present, provisions contained in different policies may vary greatly, and the premiums charged will vary as well. Therefore, it is important for you to evaluate and compare various LTCI policies to ensure that you purchase a policy that best fits your needs, financial and otherwise. To compare the cost of two policies accurately, you'll need to ensure that each policy provides the specific benefits that you require.

While it's important for you to review the provisions of each policy, it's also essential to research the financial stability of the issuing insurance company and to decide whether you want to purchase a traditional policy or one of the new tax-qualified policies. And if you already own an LTCI policy, you might wish to consider switching plans or upgrading coverage. This might be appropriate, for instance, if you're in good health and have an old LTCI policy that was highly restrictive (e.g., it required you to have a prior hospital stay before benefits would kick in). Most of the newer policies are less restrictive and offer the added advantage of inflation protection. In terms of conserving your policy, you'll want to make sure that you pay your premiums in a timely fashion and follow all applicable requirements to ensure that your policy remains in effect.

How should you evaluate and compare long-term care insurance (LTCI) policies?

Many factors are involved in selecting a suitable LTCI policy. The best policy for you depends on your family arrangement, your financial situation, your preferences regarding long-term care choices, and the level of risk you are willing to accept. There is no one best company or one best policy for everyone. You should select a policy that meets your needs. But before analyzing different policies, you should complete the following steps:

- Obtain sample policies and outlines of coverage from each carrier you are considering. The outline of coverage summarizes the policy's benefits and highlights the important features.
- Review the company's rating and financial strength (discussed later).
- Determine the current cost of long-term care in the area in which you live (or the area in which you intend to move). You can do that by contacting nursing homes, home health care agencies, adult day cares, and state elder affairs offices.

Next, you need to read the actual policies carefully, making sure you understand each provision. After you've made sure that each policy contains the provisions you desire, you'll want to compare prices. Finally, you might wish to consult with an agent, financial planner, or other professional to ensure that you've selected the policy that will best suit your needs.

Cost of long-term care insurance (LTCI)

Because LTCI premiums are based on age at the time of purchase, the younger you are when you purchase a policy, the less expensive the annual premium will be. The premiums for most policies stay level each year as you age (unless your state's insurance commission approves a rate increase for all persons within a given class). Therefore, if you buy at age 55 a policy that costs \$800 per year, it is likely that you will continue to pay the same premium. However, if you wait until you are 65 to buy a policy, the same policy might cost you \$1,700 per year. For more information about cost, see *Determining the Need for Long-term Care Insurance (LTCI): How Much Is Enough?*



In general, premiums for LTCI begin to accelerate each year around age 65. Rates increase dramatically for those buying coverage in their 70s and 80s. Nevertheless, it probably makes little sense to buy a policy before age 50. This is because you'll probably end up paying premiums for many years unnecessarily, considering that most people don't enter nursing homes in their 50s. Bear in mind that an inexpensive policy is not necessarily the best policy. Furthermore, it's difficult to compare premium costs between two plans, since the cost for care fluctuates between insurers, issue ages, and benefit levels. It's important, therefore, to review the provisions of each policy to make any price differential more meaningful. For instance, it may be that the policy with the higher premium allows you the flexibility to receive care in virtually any setting, whereas the policy with the lower premium limits care to a skilled nursing home.

Comparing provisions

You'll want to determine that certain necessary provisions are included in the policy while keeping in mind that the more features or benefits the policy has, the more expensive it will be. Questions that should be addressed when evaluating an LTCI policy include the following:

- What long-term care services are covered? Does the policy cover skilled nursing, intermediate care, custodial care, home health care, and adult day care?
- Is the policy renewable regardless of the insured's age or physical or mental condition?
- How do you qualify for benefits?
- When do benefits begin? Is there a waiting or elimination period?
- How long will the policy pay benefits?
- How much does the policy pay? What is the minimum and maximum daily benefit amount that you can purchase?
- Will benefits increase with inflation?
- Is the policy tax qualified?
- Can the policy be upgraded if the insurance company offers an improved policy?
- What conditions are specifically excluded from coverage?
- Does the policy limit benefits because of pre-existing conditions?

For more information, and for a description of various provisions contained in LTCI policies, see Long-term Care Insurance (LTCI) Provisions. See also Options and Riders.

How should you compare companies?

You should check with several companies and insurance agents before you buy an LTCI policy. And it's important to check out the financial strength of the companies you're interested in. You can determine a sound investment by reviewing the company's A. M. Best Company's rating along with the opinions of other rating services, such as Moody's or Standard & Poor's Insurance Rating Services, at your local library.

If you decide to go with an A. M. Best rating, you should select an insurance company that has received a rating of at least A or A+. This means that the investment is excellent or superior and entails very little risk. The following table outlines the various ratings:

COMPANY RATING	A. M. BEST SCORE
Superior (little risk)	A++ or A+
Excellent (slightly more risk)	A, A-



Very Good (strong claims-paying ability)	B++, B+
Fair (less protection against risk)	B, B-
Marginal (relatively high risk factor)	C++, C+
Weak (high risk factor)	C, C-
Poor	D
Under Regulatory Supervision	E
In Liquidation	F
Suspended	S

If you are financially savvy, you can also review the company's financial statements to determine its financial stability. Review the annual report and find out how long the company has been in business. (Note that this type of research might prove to be quite time consuming, however.)

For more information about insurance company ratings, see [Finding Insurance Company Rating Information](#).

What about replacing or updating your policy?

There might be situations in which canceling an existing policy and buying a new one makes sense. You should carefully compare the increased premiums to the added benefits of the new policy. Insurance companies introduce new products every few years. An older plan might be more restrictive (e.g., it might require a hospital stay before paying benefits for nursing-home care, or it might not cover assisted living).

Ask your agent about the company's record regarding policy upgrades. Many companies automatically notify existing policyholders and offer the new policy at a higher premium because of the enhanced benefits. Some companies automatically upgrade existing policies to new policies. If a policy is upgradable, you'll be able to acquire an improved policy without meeting the health requirements of a new policyholder. In some cases, it may be possible for you to replace your current policy with one of the new tax-qualified policies. Qualified policies allow certain taxpayers to deduct all or part of the premium for their long-term care insurance. However, these tax-qualified policies can be more restrictive. For more information, see [Taxation and Long-Term Care Insurance \(LTCI\)](#).

What about conserving your policy (LTCI)?

You probably shouldn't buy an LTCI policy unless you intend to keep it for the rest of your life. Unfortunately, it's all too easy for some people to allow a policy to lapse inadvertently or because they can no longer afford the premiums. "Conserving" your policy means ensuring that you pay your premiums in a timely fashion and follow all applicable requirements to keep your policy in effect.

Some companies have begun to add safeguards to make sure that the people who want to stay insured do. If you miss a premium, some companies will send a notice of a missed premium to a third party of your choosing. Some companies may offer the right to reinstate a policy after five months if it lapsed because a policyholder was cognitively or functionally impaired. Some states require these provisions. At a price, you can also purchase nonforfeiture of premiums as an option. This requires the insurance company to refund all or a part of your premiums if you hold the policy for a specified number of years before discontinuing it. For more information, see [Options and Riders](#).



Medicaid Planning Goals and Strategies

Why is Medicaid planning important?

Aging is inevitable, and a gradual (or not so gradual) inability to function independently is a great concern for many people. While the prospect of entering a nursing home is a daunting one, equally frightening is the expense of nursing home care. Although purchasing long-term care insurance might be the most logical move, not everyone can afford the cost of its premiums. Many people feel that their only option is to spend down their life savings in order to private-pay nursing home care. Once this money has been exhausted, they'll apply for Medicaid. But this isn't the way it has to be. To qualify for Medicaid, both your income and the value of your assets must fall below certain limits, which vary from state to state. In determining your eligibility for Medicaid, a state may count only the income and assets that are legally available to you for paying your bills. Consequently, a number of tools have arisen to facilitate Medicaid qualification.

What are the goals of Medicaid planning?

Medicaid planning serves to accomplish a number of goals: (1) qualifying for Medicaid, (2) exchanging "countable" assets for exempt assets, (3) preserving assets (including the family home) for loved ones, and (4) protecting the healthy spouse (if any).

Qualifying for Medicaid

Qualifying for Medicaid is not automatic; your income and asset levels must fall below the threshold set by your state. However, a state may consider only the income and assets that are legally available to you for paying your bills. Medicaid planning helps you to qualify for Medicaid.

Exchanging countable assets for exempt assets

The term countable assets refers to anything valuable you own that is not exempt by law or otherwise made inaccessible; the total value of your countable assets (together with your nonexempt income) will determine your eligibility for Medicaid. Under federal guidelines, each state composes a list of exempt assets. It is possible, therefore, to rearrange your finances so that countable assets are exchanged for exempt assets (or otherwise made inaccessible to the state).

Preserving assets (including the family home) for loved ones

Why are so many people averse to simply liquidating their assets to pay for nursing home care? After all, Medicaid will eventually step in (in most states), once you've exhausted your personal resources. The reason is simple: People want to financially assist their loved ones. After working long hours for many years, over the course of a lifetime, most people don't want to see their nest eggs vanish; rather, they want to be able to pass something down to their loved ones. And this can be particularly true with respect to the family home, which is often the single largest asset a nursing home resident might own.

Protecting the healthy spouse (if any)

With respect to a married couple, financial protection of the healthy or at-home spouse is always an important concern. A married couple's assets are pooled together when the state is considering the eligibility of one spouse for Medicaid. The healthy spouse is entitled to keep a spousal resource allowance, which generally amounts to one-half of the assets (not to exceed \$109,560 in 2011). This really isn't much money, especially if the healthy spouse is a younger woman (who'll probably live much longer anyway because of her gender). Medicaid planning seeks to financially assist the healthy spouse.

What are the primary tools and strategies for attaining these goals?



Purchase of exempt assets

It has become standard practice for a Medicaid applicant to use countable resources to purchase exempt assets. Exempt assets are those that do not affect your eligibility for Medicaid; each state composes a list of exempt assets, based on federal guidelines. Typically, this list may include such items as a family home, prepaid burial plots and contracts, one automobile, and term life insurance.

Instead of spending your money solely on nursing home bills, therefore, you can pay off the mortgage on your family home, make home improvements and repairs, pay off your debts, purchase a car for your healthy spouse, and prepay burial expenses.

Caution: For Medicaid applications filed on or after January 1, 2006 (this date may be slightly different in your state), a family home with equity above \$500,000 (or \$750,000 if increased by your state) makes you ineligible for Medicaid. An exception applies if your spouse, child under age 21, or child who is blind or disabled resides in the home.

Using immediate annuities to convert countable assets into an income stream

A healthy spouse may want to take jointly owned, countable assets to purchase a single premium immediate annuity that is Medicaid-compliant for the benefit of himself or herself alone. You convert countable assets into an income stream. This is beneficial, since each spouse is entitled to keep all of his or her own income. (This stands in contrast to the treatment of assets, whereby all assets of a married couple are pooled together and totaled.) By purchasing an immediate annuity in this manner, the institutionalized spouse can qualify more easily for Medicaid, and the healthy spouse can enjoy a higher standard of living.

Caution: Generally, for annuities purchased on or after February 8, 2006 (this date may be slightly different in your state), the annuity will be counted as an asset unless the state is named as the primary beneficiary (unless the beneficiary is your spouse or minor or disabled child), in which case the state must be named as the secondary beneficiary. There is an exception for annuities held within a retirement plan. Further, any interest you have in an annuity must be disclosed at the time you apply for Medicaid.

Transfer of assets under "reverse half-a-loaf"

Prior to the enactment of the Deficit Reduction Act of 2005 (the Act), the "half-a-loaf" strategy was often used to preserve assets and facilitate eligibility for Medicaid. Basically, you would give approximately one-half of your assets away (to loved ones) in order to preserve those assets; you used the remaining money to pay for your nursing home care during the period of ineligibility for Medicaid caused by the transfer. This strategy worked because the period of ineligibility was triggered when the transfer was made. Under the Act, the period of ineligibility now starts when you apply for benefits, effectively eliminating the half-a-loaf strategy in most cases.

But since the enactment of the Deficit Reduction Act, a strategy referred to as "reverse half-a-loaf" is being used. With a reverse half-a-loaf, you transfer assets to loved ones in an amount that will qualify you for Medicaid in the same month that you apply for benefits. Due to this transfer, a period of ineligibility will apply. You then purchase an annuity or a promissory note that will "cure the transfer" by having a portion of the transfer returned, which shortens the eligibility period.

Caution: The reverse half-a-loaf strategy is not permitted in all states. It will not work in states that do not allow partial cures. An attorney or advisor who is experienced with Medicaid planning can give you more information about the rules in your state.

Trusts

An irrevocable trust can help you to qualify for Medicaid and preserve assets for your loved ones; it serves to shelter your assets (and/or income), making them unavailable to you. The state Medicaid authorities cannot consider assets that are truly inaccessible to the Medicaid applicant; therefore, anything that stays in an irrevocable trust will lie outside of your financial picture, for Medicaid eligibility purposes.

Although a number of trusts have been devised by Medicaid planning attorneys, four have received particular note



and the most widespread acceptance: (1) irrevocable income-only trusts, (2) irrevocable trusts (in which the creator of the trust is not a beneficiary), (3) Miller trusts, and (4) special needs trusts.

Preservation of principal residence through outright transfers, life estates, special powers of appointment, and transfers into trust

For many people, a house is generally the most valuable and important asset they own. Not only does it have sentimental value, but it is sometimes the only means of passing down some financial security to children or other loved ones. However, the skyrocketing cost of nursing home bills can jeopardize your ability to preserve your house. Additionally, a state may be entitled to seek reimbursement for Medicaid payments by, in some cases, placing a lien on your principal residence.

However, utilizing certain Medicaid planning techniques may help you preserve your home for your loved ones:

- **Outright transfers (gift of the home)**--Making a gift of your home to your children protects this asset for them; the state cannot place a lien (or force a sale) on a home that no longer belongs to you and is not part of your estate.
- **Transfer subject to life estate**--With this planning tool, you transfer the remainder interest in your house to your loved ones, and you keep a life estate for yourself. You have the legal right to live in the house, and when you die, your loved ones will own the home automatically.
- **Transfer subject to special power of appointment**--Here, you transfer your house to someone else but reserve the right to later redirect the ownership of the house to a different person. Since the house no longer belongs to you, the state cannot place a lien (or force a sale) on it. And this tool provides you with tax advantages as well.
- **Transfer in trust**--From a Medicaid perspective, the most effective form of trust for protecting your principal residence would be the irrevocable income-only trust. It can facilitate your Medicaid eligibility and remove the house from your probate estate, protecting it from a Medicaid-forced sale in some states.

Durable power of attorney

Your possible incapacity in the future should be a concern. If you become mentally incompetent before you enter a nursing home, it may be very difficult (if not impossible) to effect a transfer of your assets. A durable power of attorney is a written instrument you sign, authorizing someone else to act for you in the event that you become incapacitated. That way, for example, a wife can transfer the family home out of her husband's name and into her own even after her husband becomes too ill to manage his own affairs.

How does long-term care insurance factor in?

Because Medicare and other forms of health insurance do not pay for custodial care (assistance with daily activities), many nursing home residents have only three alternatives for paying their nursing home bills: cash, Medicaid, and long-term care insurance (LTCI). By purchasing LTCI while you are still healthy, you can hold onto the bulk of your assets for as long as possible--there is no need for you to divest yourself of assets through trusts and other planning tools years ahead of time. Since your insurance will subsidize your nursing home bills during your first few years, you can transfer assets to your loved ones after you enter a nursing home. Any Medicaid ineligibility period created by your transfer of assets will be harmless; your insurance company will pay your bills during that time period.

On the downside, the insurance premiums might be too expensive for a person of modest means. You must consider not only whether you can afford the premiums now but also whether you'll be able to continue paying the premiums in the future (when your income might be substantially decreased).

Tip: All 50 states are permitted to participate in the Long-Term Care Partnership Program. The Partnership Program combines private LTC insurance with Medicaid. Those who purchase LTC insurance through the program receive certain benefits such as the ability to protect some or all of their assets from the "spend down" requirements of the eligibility process.



What are the drawbacks to Medicaid planning?

Medicaid planning can involve certain risks and drawbacks. In particular, you need to be aware of "look-back" periods and possible disqualification for Medicaid, potential criminal penalties, and adverse tax consequences. Because the Medicaid transfer rules have been tightened in recent years (and may continue to contract in the years ahead), you should consult with an attorney experienced with Medicaid planning.

Look-back period

When you apply for Medicaid, the state has the right to review or look back at your finances (and those of your spouse) for a period of months before the date you applied for assistance. For transfers made on or after February 8, 2006 (the date of enactment of the Deficit Reduction Act of 2005), the look-back period is 60 months.

Certain transfers of countable assets for less than fair market value, made during the look-back period, will result in a waiting period or period of ineligibility before you can start to collect Medicaid benefits. The formula for determining the waiting period may be explained as the fair market value of the transferred assets divided by what Medicaid determines to be the average monthly cost of nursing homes in your locale, the quotient representing the number of months for which you will be ineligible for certain Medicaid benefits.

Example(s): Assume that Ralph used \$288,000 to create an irrevocable trust, naming himself as beneficiary and his friend as trustee. Ralph entered a nursing home two years later at the rate of \$6,000 per month (which is the average in his locale) and applied for Medicaid. But because Ralph transferred assets to an irrevocable trust during the look-back period (60 months), he will be ineligible to receive Medicaid benefits for 48 months (\$288,000 divided by \$6,000 equals 48 months).

It is possible, therefore, that engaging in Medicaid planning can actually cause you to become ineligible for Medicaid for a time.

Penalties

If you transfer assets for less than fair market value, you should apply for Medicaid only after the ineligibility period (if any) has elapsed.

Adverse tax consequences

If you give away your assets during your lifetime, the recipients (beneficiaries) will step into your shoes in a tax sense--they'll get the same tax basis in the assets that you had possessed. That can be a drawback, since your holding onto the assets until death would provide the recipients with a stepped-up basis; that is, the fair market value of the assets on your date of death would become the tax basis for your beneficiaries. Nevertheless, certain Medicaid planning tools can preserve the stepped-up basis, even when you effect lifetime transfers. It is important, therefore, to evaluate your Medicaid planning strategies from all perspectives, including a tax viewpoint. What may be the most wise decision from a Medicaid standpoint might be a poor move from a tax standpoint. (Tools that won't prevent the ultimate recipients of your assets from getting a stepped-up tax basis upon your death include the following: Transfer Subject to Life Estate, Transfer Subject to Special Power of Appointment, and Transfer in Trust.) For more information, consult a financial professional or an elder law attorney experienced with Medicaid planning.



Helping people avoid financial blind spots so they can keep more of their wealth and enjoy financial independence!



**New England Consulting
Grp of Gfld, Inc.**
Tom J. Perrone, CLU
President
2514 Boston Post Rd
C-2
Guilford, CT 06437
203-453-0471
tpnecgginc@comcast.net
www.necgg.com

